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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANNA CATHERINE DASHER** **1107 28th Street, Apt. A** **San Diego, CA 92102** **Registered Nurse License No. 683312** Respondent.	Case No. 2011-735 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 14, 2006, the Board of Registered Nursing issued Registered Nurse License Number 683312 to Anna Catherine Dasher (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 482 of the Code states:

> Each board under the provisions of this code shall develop criteria to evaluate the rehabilitation of a person when:
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> (a) Considering the denial of a license by the board under Section 480; or
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> (b) Considering suspension or revocation of a license under Section 490.
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> Each board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee.

7. Section 490 of the Code provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

8. Section 493 of the Code states:

> Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law to deny an application for a license or to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the ground that the applicant or the licensee has been convicted of a crime substantially related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact, and the board

may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, and duties of the licensee in question.

As used in this section, "license" includes "certificate," "permit," "authority," and "registration."

9. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof. . . .

10. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

11. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

12. Section 4060 of the Code states, in pertinent part, that no person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor.

REGULATORY PROVISIONS

13. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

14. California Code of Regulations, title 16, section 1444, states:

A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

(b) Failure to comply with any mandatory reporting requirements.

(c) Theft, dishonesty, fraud, or deceit.

(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code.

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15. California Code of Regulations, title 16, section 1445 states:

. . . .

(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:

(1) Nature and severity of the act(s) or offense(s).

(2) Total criminal record.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the licensee.

COSTS

16. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

17. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K), and is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Meperdine, also known by the brand name Demerol, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and is a dangerous drug pursuant to Business and Professions Code section 4022.

19. Morphine sulfate, also known by the band name MS Contin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

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FACTUAL ALLEGATIONS

Division of Investigation Case No. 2009-01171-RN

20. Respondent was employed by Sharp Memorial Hospital (SMH) in San Diego from July 10, 2006, to April 16, 2009. Respondent was assigned to the Emergency Department of SMH on 12-hour night shifts.

21. On September 15, 2006, as part of Respondent's orientation, she acknowledged receipt and training on SMH's Policy and Procedures. *The Policy and Procedure for Medication Administration* required that all administered medications be documented on the appropriate medication administration record (MAR), narcotics were to be signed out on the controlled substances/narcotics inventory sheet, and all wastage must be documented on the narcotic inventory sheet and in Pyxis.[1] SMH's *Policy and Procedures for Controlled Substances* required that "All authorized nurses accurately document the administration and disposition of Controlled Substances (Schedule II-IV) on the patient's Medication Administration Record, the Narcotic Administration Record (NAR), or the Pyxis electronic record, as applicable, in compliance with the Controlled Substances Policy and the Pyxis Medstation Use Policy. This includes patient name, drug, amount used, date/time, and signature of the authorized nurse (a co-signer is required for inventory, wastage and resolving any discrepancy)." Information for wastage must be entered into the Pyxis Medstation and witnessed and co-signed by two authorized nurses.

22. In February 2009, a routine narcotics usage audit at SMH revealed an abnormally high incidence of narcotics usage by Respondent. Reviews of the Pyxis narcotic usage and waste reports, and patient medical administration records (MAR) revealed a significant pattern of unaccounted narcotics for the audit period from January 3 to January 21, 2009. SMH conducted an internal investigation which revealed that during Respondent's twelve work shifts, a total of 33

[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

mg of hydromorphone, 250 mg of meperdine, and 16 mg of morphine sulfate were unaccounted for. Respondent was questioned by SMH, but she could not provide a plausible answer for the unaccounted narcotics, and denied diverting the narcotics for her own use. Respondent told her employers that she had been unhappy in her job and had become sloppy. She pulled extra medications for convenience. She said she would sometimes find syringes in her pockets when she got home from work, but stated that it happened to other nurses, too. Respondent was permitted to resign in lieu of termination on April 16, 2009.

23. On or about May 7, 2009, SMH filed a complaint with the Board alleging that Respondent was suspected of narcotics diversion. Based on SMH's audits, there was also a clear pattern of increasing narcotics usage from October 2008 to January 2009. The internal review of SMH identified 33 patient charts containing the following discrepancies dating from January 3, 2009 to January 19, 2009:

24. Patient 1 (January 3, 2009): Respondent removed 2 mg of hydromorphone from Pyxis at 1929 hours for this patient not under her care. Respondent recorded wasting 1.5 mg hydromorphone at 2344. (The patient was discharged at 2132.) The last dose of medication charted in the patient's MAR was at 1450 by another nurse. One-half (.5) mg hydromorphone was unaccounted for.

25. Patient 2 (January 4, 2009): Respondent removed 2 mg hydromorphone from Pyxis for this patient at 0432 and did not chart the administration in the patient's MAR, or record it wasted. The last dose charted was at 0335 by another nurse. Two (2) mg of hydromorphone was unaccounted for.

26. Patient 3 (January 4, 2009): Hydromorphone 0.5 mg was ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis at 2024 and did not chart its administration in the patient's MAR, or record it wasted. The last dose of hydromorphone (0.5 mg) was charted in the patient's MAR at 1822 by another nurse. Two (2) mg of hydromorphone was unaccounted for.

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27. Patient 4 (January 4, 2009): Hydromorphone 0.5 mg was ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis at 1952 and did not chart the administration in the patient's MAR. The last dose of hydromorphone (0.5 mg) was recorded in the patient's MAR at 1754 by another nurse. The patient was discharged at 1941. Respondent recorded 1.5 mg hydromorphone wasted at 2212, over two hours later.

28. Patient 5 (January 5, 2009): Respondent removed 2 mg of hydromorphone from Pyxis at 0158 and did not chart the administration in the patient's MAR, or record it wasted. The last dose of hydromorphone was recorded in the patient's MAR at 2308 (January 4th) by another nurse. The patient was discharged at 0105. Two (2) mg of hydromorphone was unaccounted for.

29. Patient 6 (January 5, 2009): Respondent removed 50 mg of meperidine from Pyxis at 0359. There was no order for meperidine for this patient, and its administration was not charted in the patient's MAR. Respondent wasted 50 mg meperdine at 0300, one hour earlier than it was withdrawn.

30. Patient 7 (January 5, 2009): Respondent removed 2 mg of hydromorphone from Pyxis at 1920 and did not chart the administration in the patient's MAR, or record it wasted. All other MAR entries were by other nurses. Two (2) mg of hydromorphone was unaccounted for.

31. Patient 8 (January 5, 2009): Respondent removed 2 mg of hydromorphone from Pyxis at 1959. There was no order for hydromorphone for this patient. Respondent did not chart its administration in the patient's MAR, or record it wasted. Two (2) mg of hydromorphone was unaccounted for.

32. Patient 9 (January 5, 2009): Hydromorphone 1 mg was ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis at 2147. Respondent charted she administered 1 mg at 2152. No wastage was recorded. Respondent removed 2 mg of hydromorphone from Pyxis at 2222. Respondent charted she administered 1 mg at 2258. No wastage was recorded. Respondent removed 1 mg of hydromorphone from Pyxis at 2317 and did not chart its administration in the patient's MAR. Respondent wasted 1 mg hydromorphone at 0614. Two (2) mg of hydromorphone was unaccounted for.

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33. Patient 10 (January 5, 2009): Meperdine 100 mg was ordered for this patient. Respondent removed 50 mg meperdine from Pyxis at 0613 and the administration was not charted in the patient's MAR, or recorded wasted. Another nurse withdrew and administered 50 mg meperdine at 0514. Fifty (50) mg of meperdine was unaccounted for.

34. Patient 11 (January 10, 2009): Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 1918 and charted the administration of 1 mg hydromorphone at 1929. Respondent removed 2 mg hydromorphone at 2008 and did not chart its administration in patient's MAR. Respondent removed 1 mg hydromorphone at 2202 and did not chart its administration in patient's MAR. Respondent recorded 1 mg hydromorphone wasted at 0118. Three (3) mg of hydromorphone was unaccounted for.

35. Patient 12 (January 10, 2009): Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 1952 and charted the administration of 1 mg at 1959. Respondent did not record 1 mg hydromorphone wasted until 0638, over 10.5 hours later.

36. Patient 13 (January 11, 2009): Respondent removed 50 mg meperdine from Pyxis at 0646. There was no order for meperdine for this patient. Respondent did not chart its administration in the patient's MAR, and it was not recorded wasted. Fifty (50) mg of meperdine was unaccounted for.

37. Patient 14 (January 11, 2009): This patient had an order for 4 mg MS Contin. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 0415. There was no order for hydromorphone and Respondent and did not chart its administration in patient's MAR, or record it wasted. Respondent removed 10 mg morphine at 0444 and did not chart its administration in patient's MAR, or record it wasted. Another nurse charted the administration of 4 mg MS Contin to this patient at 0310. Two (2) mg of hydromorphone and six (6) mg morphine was unaccounted for.

38. Patient 15 (January 12, 2009): This patient had an order for 4 mg MS Contin. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 1915. There was no order for hydromorphone and Respondent and did not chart its administration in patient's MAR,

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or record it wasted. Another nurse charted the administration of 4 mg MS Contin to this patient at 2117. Two (2) mg of hydromorphone was unaccounted for.

39. Patient 16 (January 12, 2009): Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 2000 and did not chart its administration in patient's MAR, or record it wasted. Another nurse charted the administration of 2 mg hydromorphone at 2020. Two (2) mg of hydromorphone was unaccounted for.

40. Patient 17 (January 12, 2009): This patient had an order for 0.2 – 0.4 mg hydromorphone, as needed. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 2320 and did not chart its administration in patient's MAR, or record it wasted. Another nurse charted the administration of two doses of hydromorphone 0.4 mg at 2324 and again at 0127. Two (2) mg of hydromorphone was unaccounted for.

41. Patient 18 (January 14, 2009): This patient had an order for 50 mg meperdine. Respondent removed 50 mg meperdine from Pyxis at 0436 and did not chart its administration in the patient's MAR, or record it wasted. Another nurse charted the administration of 50 mg meperdine at 0319. Fifty (50) mg of meperdine was unaccounted for.

42. Patient 19 (January 14, 2009): This patient had an order for 0.6–1 mg hydromorphone, as needed. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 1916 and did not chart its administration in patient's MAR. Two nurses charted the administration of hydromorphone at 1836 and 0053. Respondent removed 100 mg of meperidine from Pyxis at 0646. There was no order for meperidine for this patient, its administration was not charted in the patient's MAR, or wastage recorded. Two (2) mg of hydromorphone and one hundred (100) mg of meperdine was unaccounted for.

43. Patient 20 (January 14, 2009): This patient had an order for 1 mg hydromorphone. Respondent removed 1 mg of hydromorphone from Pyxis for this patient at 2220 and did not chart its administration in patient's MAR, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

44. Patient 21 (January 14, 2009): This patient had an order for 4 mg MS Contin. Respondent removed 10 mg of MS Contin from Pyxis for this patient at 0425. Respondent did

not chart its administration in patient's MAR, or record it wasted. Ten (10) mg of MS Contin was unaccounted for.

45. Patient 22 (January 15, 2009): This patient had an order for 0.5 mg hydromorphone. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 0711 and did not chart its administration in patient's MAR, or record it wasted. Another nurse charted the administration of 0.5 mg hydromorphone at 0719. One and one-half (1.5) mg of hydromorphone was unaccounted for.

46. Patient 23 (January 17, 2009): This patient had an order for 1 mg hydromorphone. Respondent removed two doses of 2 mg of hydromorphone from Pyxis for this patient at 1911 and 1955 and did not chart its administration in patient's MAR. One (1) mg hydromorphone was recorded wasted at 0631. Three (3) mg of hydromorphone was unaccounted for.

47. Patient 24 (January 17, 2009): This patient had an order for 1 mg hydromorphone. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 0153 and did not chart its administration in patient's MAR. Another nurse charted the administration of hydromorphone at 0001 and 0241. Respondent recorded 1.4 mg of hydromorphone wasted at 0450.

48. Patient 25 (January 18, 2009): This patient had an order for 4 mg MS Contin. Respondent removed two doses of 1 mg hydromorphone from Pyxis for this patient at 0015. No hydromorphone was ordered for this patient. Respondent did not chart its administration in patient's MAR, but recorded 1 mg wasted at 0632, six hours later. One (1) mg hydromorphone was unaccounted for.

49. Patient 26 (January 18, 2009): No medications had been ordered for this patient. Respondent removed 1 mg of hydromorphone from Pyxis for this patient at 2230 and did not chart its administration in patient's MAR, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

50. Patient 27 (January 18, 2009): This patient had an order for 0.5-1 mg hydromorphone. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 2310. Two nurses charted administering 0.5 mg hydromorphone at 2025 and 2311. Respondent

charted the administration of 0.5 mg at 0039. No wastage was recorded. One-half (0.5) mg of hydromorphone was unaccounted for.

51. Patient 28 (January 18, 2009): This patient had an order for 1 mg hydromorphone. Respondent removed two doses of 2 mg hydromorphone from Pyxis for this patient at 1954 and 2233. Another nurse charted the administration of 1 mg at 1950. Respondent charted the administration of 1 mg at 2242. No wastage was recorded. Two (2) mg of hydromorphone was unaccounted for.

52. Patient 29 (January 19, 2009): This patient had an order for hydrocodone. Respondent removed 2 mg hydromorphone from Pyxis for this patient at 1921. There was no order for hydromorphone for this patient, its administration was not charted in the patient's MAR, and no wastage was recorded. Two (2) mg of hydromorphone was unaccounted for.

53. Patient 30 (January 21, 2009): No medications had been ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 2048 and did not chart its administration in patient's MAR, or record it wasted. Two (2) mg of hydromorphone was unaccounted for.

54. Patient 31 (January 21, 2009): No medications had been ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 1914 and did not chart its administration in patient's MAR, or record it wasted. Two (2) mg of hydromorphone was unaccounted for.

55. Patient 32 (January 21, 2009): No medications had been ordered for this patient. Respondent removed 2 mg of hydromorphone from Pyxis for this patient at 2339 and did not chart its administration in the patient's MAR. Two (2) mg hydromorphone was recorded wasted at 0433, five hours later.

56. Patient 33 (January 19, 2009): This patient had an order for hydrocodone. Respondent removed 2 mg hydromorphone from Pyxis for this patient at 2053. There was no order for hydromorphone for this patient, its administration was not charted in the patient's MAR, and no wastage was recorded. Two (2) mg of hydromorphone was unaccounted for.

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57. The Division of Investigations (DOI) assigned an investigator to the matter. In the course of the DOI investigation, the interim manager of the Emergency Department stated that if she had a nurse who was having issues charting the administration of medications in the patients' MAR, she would expect to see charting errors with other medications as well. Respondent's charting errors were specific to the narcotics meperdine, hydromorphone, and morphine sulfate.

DOI Contact With Respondent

58. In an interview with Respondent on August 3, 2010, Respondent stated to the DOI investigator that she would sometimes remove medications from Pyxis "proactively" based on the patient's condition without waiting for the doctor's orders to be entered into the hospital's system. Respondent denied diverting drugs, but still had no plausible explanation for the missing narcotics. She stated that she was currently prescribed meperdine and morphine for back pain due to degenerative disk disease.

59. The DOI investigator obtained a copy of Respondent's Patient Activity Report (PAR) from the Controlled Substance Utilization Review and Evaluation System (CURES)[2] for the period April 19, 2008 to July 16, 2010. Respondent's PAR indicates that from April 2008 to August 2010, she was being treated by numerous health care professionals who were prescribing sometimes overlapping prescriptions for the controlled substances hydrocodone/APAP (Vicodin/Norco), MS Contin (morphine sulfate), hydromorphone (Dilaudid), alprazolam (Xanax), and diazepam (Valium), which Respondent filled at multiple San Diego pharmacies. The PAR indicates an increasing use of morphine and hydromorphone; from May 11, 2010 to July 16, 2010, Respondent filled prescriptions for 315 tablets of morphine sulfate 100 mg, 730 tablets of hydromorphone 4 mg, and 210 tablets of diazepam 5 mg.

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[2] The Patient Activity Report (PAR) is compiled from information maintained in the Department of Justice's Controlled Substance Utilization Review and Evaluation System. CURES maintains Schedule II, Schedule III, and Schedule IV prescription information that is received from California pharmacies and is therefore only as accurate as the information provided by the pharmacies.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

60. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was grossly negligent, as defined by California Code of Regulations, title 16, section 1442, in that during the period from January 3, 2009 to January 21, 2009, while employed by SMH (as detailed in paragraphs 20-58, above), Respondent repeatedly removed controlled substances from Pyxis and failed to properly document her handling of the narcotics in the hospital's MAR's, medical records, or Pyxis. Respondent repeatedly failed to properly document wastage, repeatedly removed more medication than was ordered or necessary, removed medication that was not ordered, and routinely kept controlled substances in her personal possession without properly accounting for said medications. Respondent further withdrew medications for patients who were not assigned to her, and wasted medications outside the prescribed timeframe to do so. Respondent's actions demonstrated an extreme departure from the standard of care in that she repeatedly exposed patients to significant harm by failing to properly chart and record medication administration.

SECOND CAUSE FOR DISCIPLINE

(Illegal Possession of Controlled Substances)

61. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as detailed in paragraphs 20-58, above, Respondent obtained and possessed in violation of law controlled substances taken from her employers.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate Documentation in Hospital Records)

62. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 20-58, above, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis records pertaining to controlled substances prescribed to patients under her care.

FOURTH CAUSE FOR DISCIPLINE

(August 4, 2006 Criminal Conviction for Driving Under the Influence on March 4, 2006)

63. Respondent has subjected her registered nurse license to disciplinary action under sections 490 and 2761, subdivision (f) of the Code in that Respondent was convicted of a crime that is substantially related to the qualifications, functions, and duties of a registered nurse. The circumstances are as follows:

a. On or about August 4, 2006, in a criminal proceeding entitled *People of the State of California v. Anna Catherine Dasher,* in San Diego County Superior Court, case number M987480, Respondent was convicted on her plea of no contest of violating Vehicle Code section 23152, subdivision (a), driving under the influence of alcohol. Count Two, violating Vehicle Code section 23152, subdivision (b), driving with a blood alcohol concentration (BAC) of 0.08% or more, was dismissed pursuant to a plea agreement.

b. As a result of the conviction, on or about August 4, 2006, Respondent was sentenced to five years summary probation and ordered to serve 180 days in the county jail, suspended. Respondent was required to complete nine days of public work service. On or about October 26, 2006, the public work service was terminated when Respondent's doctor attested to her "total disability" (even though Respondent was working full-time as a registered nurse at a San Diego hospital at the time). Respondent was further ordered to complete a first offender DUI program, pay $1,750 in fees, fines, and restitution, and comply with the terms of DUI probation.

c. The facts that led to the conviction are that on or about midnight of March 4, 2006, a patrol officer from the San Diego Police Department came upon Respondent sitting behind the wheel of her vehicle, engine running, and smoking a cigarette. She had crashed into a parked car. When the officer asked Respondent what happened, she replied "I'm drunk." Respondent had the odor of an alcoholic beverage on her breath, her eyes were droopy and exhibited distinct nystagmus, and she was unsteady on her feet. Respondent submitted to a series of field sobriety tests which she failed to perform as explained and demonstrated. Respondent was arrested for driving under the influence. At booking, she provided a blood sample which was analyzed with a BAC of .23 percent.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of Alcohol in a Dangerous Manner)

64. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (b) of the Code in that on or about March 4, 2006, as described in paragraph 63, above, Respondent used alcoholic beverages to an extent or in a manner that was dangerous and injurious to herself, and potentially dangerous to others in that she operated a motor vehicle with a significantly high BAC (.23%), nearly three times the legal limit, and caused an accident.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Conviction of Alcohol-Related Criminal Offenses)

65. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (c) of the Code in that on or about August 4, 2006, as described in paragraph 63, above, Respondent was convicted of a criminal offense involving the consumption and/or self-administration of alcohol, which constitutes unprofessional conduct.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 683312, issued to Anna Catherine Dasher;

2. Ordering Anna Catherine Dasher to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/28/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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